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Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The Center is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Department of Mental Health. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay if the patient is able to pay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the professional staff, educational films, individual consultations with staff members, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the medical director, one other physician, a psychiatric social worker, psychologist, chaplain and admitting officer, vocational rehabilitation counselor, activities director, and a full attendant staff.

The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment in response to written or telephone request to the Medical Director of the Center, 406 Central Avenue, Butner, N. C., expressing voluntary desire for treatment. All appointments must be confirmed by mail and should preferably be made by the patient's physician or by other professional personnel in the patient's community, for example, alcoholism information center personnel.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history, compiled by the patient's family physician, are necessary.

3. A fee of $75, in cash or certified check, must be paid upon admission if the patient is able.

4. Sign a letter-statement requesting voluntary admission at the time of admission.

It is especially important that patients applying for admission have a thorough medical examination and be in good physical condition at the time of their admission. The Center is not a hospital or a sobering up facility and patients desiring admission should have been sober for at least seventy-two hours and should not be exhibiting withdrawal symptoms. There are no facilities provided at the Center for the treatment of physical illness. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

Wednesday, Thursday and Friday during the morning and afternoon. Patients may have visitors after they've been at the Center for 2 weeks. Visiting hours are from 1:00-4:00 P.M. on Saturday and Sunday.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA DEPARTMENT OF MENTAL HEALTH

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THE LAW AND ALCOHOLISM

BY

WEBSTER MYERS, L.L.D.

THE use of alcoholic beverages and, particularly, excessive drinking involves the law in a variety of ways. Although alcoholism is frequently implicated, it is seldom distinguished or defined. Laws deal primarily with behavior; motivation is often ignored. Thus law becomes chiefly concerned with the resultant behavior following the immoderate use of alcohol.

Usually the judge encounters such common classification of intoxication as "under the influence of alcohol", "habitual drunkenness", or "public drunkenness." There is no attempt in connection with these references to clarify the term alcoholism nor to distinguish between the alcoholic and the non-alcoholic. There are, consequently, no provisions for distinctions as to degrees of punishment, nor consideration as to whether the deviator is or is not addicted to alcohol. The only sensible way to examine how law deals with alcoholism is to examine how the law relates to the various alcohol problems.

Medical and public health authorities classify alcoholism as an illness, a condition characterized in its advanced stages by the loss of control over drinking—the craving or compulsion to drink. If alcoholism is authoritatively regarded as an illness, it would seem reasonable to assume that the law should likewise treat alcoholism as an illness. The merits of the disease concept of alcoholism will not be examined here, but for purposes of this article the author accepts that the authorities are correct with regard to the disease or illness classification of alcoholism. The following analysis of the areas where the lawyer and judge interpret law in relation to alcoholism and alcohol problems intentionally omits that vast body of legislation and administration dealing with liquor control; i. e., licensing, zoning, local option, state monopoly on sale of distilled alcohol.

Civil liability, in instances where the use of alcohol is involved, may concern liability for contractual obligations entered into by an intoxicated party, or liability for personal or property damage caused while the perpetrator was intoxicated. The statutes in many states place liability on a tavern owner for harm caused to others by an intoxicated patron subsequent to leaving the tavern. Questions as to whether a guardian should be appointed, because of alleged inability to perform due to alcohol addiction, and the liability of insurance companies under disability policies, also involve civil liability.

The contractual or tort liability of an intoxicant may or may not involve alcoholism. In determining contractual liability, the court is usually confronted with the opportunist, the person attempting to take advantage of artificial, favorable circumstances,

and the victim, the intoxicant. It would be patently unjust for the court to permit the opportunist to profit from this situation. If the contracting party is not aware the other party is intoxicated, or if an innocent third party is involved, the court will protect such party where to do otherwise would cause an injustice. In personal injury or property damage cases the court usually has before it an innocent party who has been injured and a not-so-innocent intoxicant who does the injuring. Someone must bear the loss, and justice would seem to fall on the side of the innocent, non-intoxicated party, even if the intoxicant is an alcoholic. Of course, if both parties are at fault neither may recover. Here fault is measured by behavior, which may or may not reflect the degree of intoxication involved.

Quite often an intoxicant does not have funds to fulfill his tort liability. As previously noted, many states have attempted to solve this problem by shifting the liability burden to the owner of the tavern which the intoxicant last frequented. Presumably the tavern owners in such states have appropriate insurance for this purpose. A more familiar countervailing solution by law is compulsory car insurance which extends wider protection against indigents in general. While alcoholics may be involved in such tort liability situations, it is highly questionable whether there would be any legal value for a determination of alcoholism to be made in these instances.

Matters of guardianship are usually handled by the probate court. The court is asked to make a determination of legal competency or incompetency. A decision of incompetency is usually based upon a finding that the individual is no longer able to fulfill his trust or to handle his property and needs protection from himself. This inability may be due to mental illness, senility, or various other disabilities, including the chronic, abnormal use of alcoholic beverages. Here alcoholism may come into focus when it may be alleged that the individual can no longer handle his affairs because of his habitual abuse of alcohol. A finding of legal incompetency is punishment only in the broad sense. Its primary purpose is to protect the individual or the family who are depending upon the property as their means of support. The dependent individual involved in this situation is often the elderly person with little means left. The family is no longer trying to hide the problem. Most often the alleged incompetent is in the advanced stages of alcoholism. Moreover, evidence is readily available because the family is usually the party requesting the guardianship.

A much more revealing position of the law with respect to alcoholism

An obligation exists with the legal profession to learn and understand alcoholism and discover what are the best legal resources available to deal with the illness.

A former Professor of Law at the Franklin University Law School, Columbus, Ohio, Webster Meyers has attended the Rutgers University School of Alcohol Studies. He was working on his S.J.D. degree at Columbia University when this article was published in *Ohio's Health*. It is reprinted in *Inventory* by permission.

can be noted in cases involving insurance coverage where the disability is caused by alcoholism. The insurance company does not deny the disability nor the factor of alcoholism but defends on the grounds that the disability was self-inflicted. The pinpointed issue is whether the progression to alcoholism is a series of voluntary and self-inflicted acts. Unhappily, the courts have generally denied recovery on the grounds that alcoholism is a self-inflicted disability. This position is obviously in direct conflict with the disease concept of alcoholism. Since the insurance company admits existence of a condition of alcoholism, certainly the court's freedom-of-choice view with respect to acquiring the disease is open to question. It is doubtful whether the court would permit the defense of self-inflicted lung cancer even if a direct relationship between the disability and smoking in the particular case could be shown. Can it be argued, therefore, that the use of tobacco is more accepted socially in our society than the use of alcohol? Perhaps the decisions are unfortunate carry-overs from the criminal law approach to be discussed next.

Law deals with alcohol problems most frequently in the criminal courts. This may come about due to a serious crime, such as murder or rape, and intoxication is pleaded as a defense, or due to driving a motor vehicle "under the influence of alcohol" charge, or by the misdemeanor route, i. e., persons charged with public drunkenness, disorderly conduct, disturbing the peace, etc.

Firmly established in the criminal law is the rule that voluntary drunkenness is no excuse for the commission of a crime. While there are sophistications involved between general or specific intent in certain crimes, this rule generally means that intoxication, whether the intoxicant is alcoholic or non-alcoholic, cannot be pleaded as a defense to a criminal charge. Critics of this position insist, since alcoholism negates voluntariness, that the basis of the rule when applied to alcoholics can be seriously questioned. One of the significant more obvious characteristics of the alcoholic is his loss of control and the craving or compulsion for alcohol. The position that alcoholics become voluntarily intoxicated cannot be justified under the disease concept. One may argue that the alcoholic voluntarily drank many years prior. This type of reasoning totally fails if one considers social drinking as an accepted social fact in our society.

While the criticism can be suggested with much logic, the critics have failed to advance the further step and explore the alternatives. First, the court would be called upon to distinguish the alcoholic. Certainly the usual plea in cases involving alcohol would be intoxication due to alcoholism. Can a judge discriminate the alcoholic from the non-alcoholic when the person is over-willing to provide the evidence? Would a social history, and the evidence furnished by an all too willing family, be of any greater accuracy? Is the medical profession any better equipped to make such a distinction where the intent is to establish a case? In other words, are there sufficiently sophisticated methods presently available, consistent wtih our present knowledge about alcoholism, for a reliable diagnosis?

If such a diagnosis could be made, then the court would be under pressure to dispose of the case accordingly. The majority of alcohol-involved criminal cases are of the violent va-

(Continued on page 27)

A Counseling Hazard

by J. D. M. Bliss, M.S.W.

ALCOHOLISM FOUNDATION OF ALBERTA

The alcoholic frequently uses a self-defeating approach when seeking help. If the counselor is aware of this, he will be better able to help him face his real problem.

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THE alcoholic as we know him is a sick person. He is often sick physically, emotionally, mentally and spiritually. The very nature of his illness has led him again and again to postpone seeking help until his situation has become too serious for him to ignore it any longer.

Strangely enough, many alcoholics can still truthfully say they have sought help from ministers, social workers, psychologists, doctors, and others, but that none of these people have understood them or their problem. There are several reasons why the alcoholic is misunderstood and rejected by many people in the general field of social service. One important reason, I suggest, for this rejection has to do with the alcoholic's frequent use of a particular approach for help. This approach is usually self-defeating unless the counsellor is sufficiently knowledgeable and skilled to recognize it and to help the alcoholic face his real problem constructively.

Here, briefly, are steps or stages in this fairly common approach used by the alcoholic (as well as some non-alcoholics) in an attempt to get help in solving his problems *on his own terms and in his own way.*

He may:

1. Confess some of many previous moral deviations or injuries to others (financial or otherwise), hospitalization or crimes, all of which may be verified because they are on record somewhere;

2. Establish close confidence by making a "special" or apparently "first time" confession which reveals a reasonable and emotionally stressful situation as an explanation for present drinking and which also appeals to the narcissism and vanity within each one of us;

3. Increase the intensity of the emotional interplay between patient and counsellor by playing one group who are "not really all bad, but you can see they have done this to me" against another group, yourself or your agency,

the "good guys who really understand me and my terrible situation." This further inflates the counsellor's ego;

4. Next, bring in partially true or distorted evidence which will intensify the emotional stress of the situation between "the stupid fellows who misunderstand me," and "you or your agency who have such wonderful and sympathetic understanding of my situation";

5. At the appropriate moment (those adept in the use of the "confidential" approach have a well-developed sense of timing) a real crisis situation is present. The mood felt by the counsellor is intensified. In effect, the alcoholic says, "I'm no good, I'm a failure; I may as well end it all," or, "much as I want to stay sober, I can't if this continues."

Pressure on Counsellor

The objective is to make the counsellor feel responsible for resolving the crisis and guilty if he does not immediately do something the alcoholic has suggested to relieve his crisis situation. For example; expect the counsellor to commit himself to a promise that might be very unwise; give material assistance such as money or clothes; approach someone whom the alcoholic should himself approach; arrange hospitalization or help him to cover up something with which it would be unwise to interfere.

A counsellor who experiences the following combination of feelings may have been subjected to such an approach: An initial feeling of self-satisfaction (and perhaps a little smugness) about having established quickly a good relationship with an obviously difficult case; feeling of doubt about whether to take the requested action; a false sense of guilt because of the doubts; strong anxiety

The responsibility for th
wants help and is willin

lest not taking the action requested will cause the alcoholic to take desperate action—perhaps get drunk, rob a store, kill himself or someone else. Accompanying the feelings of anxiety, doubt, and guilt will be a sense of urgency—"something must be done at once by someone."

The counsellor's growing discomfort and feeling of being "put on the spot" may produce marked feelings of hostility toward the alcoholic. This, in turn, intensifies guilt feelings and, as a result, he may go along with the alcoholic's wishes or, in anger, reject him entirely. If the counsellor goes along with the course of action desired by the alcoholic, he will often regret it later and so will find it increasingly diffcult to accept other alcoholics lest he be "taken in" again.

There are a few lay and professional counsellors who are "taken in" again and again. Unwise as it may be to generalize as to why these counsellors allow themselves to be victimized, I think it may be in order to mention, very briefly, two of several possible reasons why they allow it to happen:

(a) The counsellor has a strong need to make moralistic judgments in most relationships, and particularly about alcoholics and alcoholism. (This fact may be denied from conscious recognition by the counsellor.)

(b) The counsellor often has an intellectual understanding of alcoholism as an illness but, when faced with an alcoholic, is unable to accept the illness concept as a fact because of his moralistic attitudes.

The moralistic attitude implies "I must help my neighbor even though

lcoholic's recovery depends upon whether he accept the kind of help the counsellor thinks best.

he is bad." At the same time, by not fully accepting the illness concept, the counsellor assumes that the practicing alcoholic is capable of complete freedom to make choices and therefore should be allowed to do so. This combination of moralistic attitude and the assumption that the practicing alcoholic is normal enough to make rational choices will, in most instances, motivate the counsellor to "give in" to the alcoholic's plans. As a result of such action on the part of the counsellor, the alcoholic will not be able to achieve lasting sobriety and the counsellor will have his moralistic judgment of alcoholics and alcoholism more firmly entrenched.

In summary, in this method of trying to meet his great dependency needs in his own way and on his own terms, the alcoholic plays on our emotions by appealing to our vanity by judicious ego inflation; by leading up to a crisis and arousing feelings of indignation in the counsellor through suggestions that others have bungled and mishandled the alcoholic's problems; by continuing subtly to inflate the counsellor's ego—"you are the only one who has ever understood and helped me;" (he thus increases the counsellor's feeling of personal responsibility for maintaining his positive response;) and by presenting a crisis with the threat of serious results unless the counsellor resolves it in a particular way.

Feelings of doubt and anxiety and a false sense of guilt and anger on the part of the counsellor may lead to unwise compliance or rejection of alcoholics.

In the January, 1961 issue of *Progress,* an article entitled "The Clergyman and the Indigent Alcoholic" by A. W. Fraser outlines the appropriate steps for dealing with the particular approach I have mentioned. In addition to the points enumerated in that article, I suggest a further step in dealing with someone whom you know has been successfully using the above approach to avoid facing his real problem, alcoholism. These steps should not necessarily be taken in the first interview, but should be used as soon as the alcoholic has been convinced that you really can and will help him.

Get the real issue into the open somewhat in the following manner: "It seems to me that the primary problem is for you to make a decision whether or not you are going to stop drinking. You must realize that this decision is your responsibility and yours alone. Anyone who tries to help you must do it on his terms and according to the policy of the agency.

"The responsibility for your situation and your recovery does not rest upon me, or my giving you what you want; your recovery and the resolution of your problems rest squarely upon whether or not you want my help with your 'real' problem—alcoholism—and are willing to accept the help offered without trying to set your own terms and get action in the way that is most convenient and most comfortable to you.

"I am prepared to see that you get help, but the old saying, 'you can lead a horse to water but you can't make him drink' still applies. I hope you will accept my help, the kind of help I know from experience will be most successful in helping you reach better solutions to your problem. The decision is yours."

Excellent Article

I recently received the November-December issue of *Inventory* which I found very useful, especially since there was an excellent article relative to the alcoholic tuberculous patient included. Therefore, will you be good enough to send me 10 additional copies so that I can give these to the medical staff in our hospital?

I want to take this opportunity to tell you again how grateful I am to be receiving your publication as I have found many of the articles not only extremely interesting but very knowledgeable.

I shall be glad to reimburse you for any cost involved in regards to the additional copies which I have requested.

Mrs. Dorothy S. Fink
Medical Social Worker
Mount Morris Tuberculosis Hospital
Mount Morris, N. Y.

Pastor Distributes Inventory

It is eight years since I first started receiving your magazine and the number of back copies which I have on file is testimony to both the value and quality of its contents and my high esteem of the same. It is "tops" in my estimation, and a wonderful means for keeping up-to-date after the initial training I received at the Yale Summer School.

The latest edition of your magazine, however, is even better than usual—so much so that I was wondering if it would be possible for me to have at least four more copies. One I would like to put into our church library. One I would like to have for lending out to friends. The other two I would like to make available to the committee of the Community Welfare Planning Council of Greater Winnipeg which is at present making a study of services for juvenile and adult offenders in our city. I feel that it is extremely important that Judge Burnett's article be made available to them.

May I congratulate you on the fine work you are doing through the medium of your magazine and wish you all the best in the future.

Rev. Ian J. Harvey
Pastor, Silver Heights
United Church
Winnipeg, Manitoba

Tuberculous Alcoholics

I am working in a state tuberculosis hospital where a very large number of the patients are also alcoholics. Your magazine continues to be a tremendous help to me in understanding and helping my patients.

Lydia Pupek, R.N.
Elizabeth, N. J.

Request For Literature

I lived for several years in Asheville and I know something of North Carolina's fine program for the rehabilitation of alcoholics. My church's Commission on Christian Social Concerns is interested in the progress made in your state regarding treatment of alcoholics. Please send me current literature and any printed matter you may have available.

L. L. Trent
Chattanooga, Tenn.

The Clergyman and the Indigent Alcoholic

By A. W. Fraser

ALCOHOLISM FOUNDATION OF ALBERTA

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By giving of his time, his concern and his encouragement rather than rendering material assistance, the minister can better help the indigent alcoholic to help himself.

THE alcoholics you are called upon to deal with can be divided roughly into two groups: the indigent and the non-indigent. These groups present two quite different situations and require different *initial* approaches.

By the non-indigent I refer to those alcoholics who are members of your congregation or church community. They resemble the description given you earlier of the average Canadian problem drinker. They have many problems and serious ones, but they still have a home, are maintaining their families and go to work more or less regularly.

By the indigent I mean those alcoholics who come to you in a destitute condition and whose request is usually for immediate material assistance.

I am going to deal now with the second group; those alcoholics who are chronically or frequently out of work and money, or those who are transients, moving from job to job, from locality to locality and, as often as not, are in between jobs.

First, I wish to make one definite suggestion regarding your immediate response when you are approached for welfare assistance by an alcoholic who is in an obviously inebriated condition. Receive him civilly, and if possible, privately; listen to his request and tell him firmly that you follow a definite principle of not giving welfare to a person

whom you believe is intoxicated. Then tell him that you hope he will come back as soon as he is sober so that you can help him. If he is not too drunk, point out where he might apply for the kind of material help he needs. This, I feel, is the only constructive approach to the inebriated alcoholic. In this way, you encourage him toward sobriety, whereas a quick handout at such times will, in all probability, only encourage further drinking. If such an alcoholic is alarmingly sick or helplessly drunk, you may have to take protective action such as arrange for his admission to an emergency ward or call the police.

If you are approached for material assistance by someone who is not intoxicated, your position is less clearly defined, especially if you do not know him. Alcoholism is not, by any means, the sole cause of either chronic or temporary indigence. The basic situation in cases like these is that you are faced by a fellow human being who is in trouble; you are being asked to help him out of that trouble in a specific way which he has chosen.

Anyone who is in the general field of social service, whether he is a clergyman, a social worker, a doctor, a psychologist, or welfare worker, is faced frequently with these situations. We all have to follow the same general principles in our initial approach. Namely, we cannot give a distressed person intelligent, constructive help with a problem until we have some knowledge of how and why that problem arose. Until we have determined this, it is always unwise, and often harmful, to furnish the kind of immediate help that is being requested by the distressed person.

For example, if a doctor immediately grants a patient's request for 292's or a sedative to relieve some kind of distress, with no effort to determine or to treat the underlying cause of the distress, he does nothing but provide immediate relief of pain. The doctor will, therefore, soon be faced with a second and then a third request for the pain-killer. The patient is not being intelligently helped and we realize that he may at the same time be seriously harmed because the untreated basic problem may become more and more pronounced.

Similarly, when you are requested for specific help, it is your obligation to the troubled person to determine the following:

Several Considerations

1. The background circumstances of the immediate problem.
   (a) How did it develop?
   (b) Has it occurred previously and, if so, how frequently?
   (c) How did the man deal with it previously?
   (d) What were the results of his previous way of handling it?
2. Whether he is asking for help with the basic problem or for relief from one of its side effects.
3. Whether providing relief from the side effects may help the person toward resolving the basic problem or whether it may delay this by relieving him of the anxiety and distress which might otherwise motivate him to face and do something constructive about the basic problem.
4. What can he do (not what you can do) to resolve his immediate and basic difficulties, and how you can guide him into doing this.

As I mentioned, these steps apply to all problems with which we are presented. Let us suppose that after carrying out step 1 you feel that the basic problem in this case is alcohol-

ism—what do you do?

First, remember this. In most cases indigency will not be a new or particularly frightening situation for this alcoholic. He is not reacting to indigence the way you would if you were in a similar situation. In all probability he has gone through this a good number of times before and has developed a certain general technique or method of handling it. There are many levels and variations of this method, but basically it amounts to getting someone else to look after him and to resolve his immediate difficulties. This alcoholic's major concentration is on his immediate problems and he shows little awareness or concern for the underlying difficulty—alcoholism. He has become quite adroit in getting the kind of help he wants; he has been unwittingly helped and encouraged in this by those who have extended assistance to him. As long as he is reasonably successful in pursuing this method, i.e. getting others to resolve the difficulties created by his drinking, he will continue to use it, and therefore, to go down hill. You must remember that despite many previous handouts, sometimes ranging from hundreds of dollars in the early stages of alcoholism to a dollar or two in the late stages, he has not been effectively helped by these handouts or he would not be at your door now.

You can help him most by trying to break, or at least to interrupt, this habitual pattern. Don't reinforce it by an easy handout. Try to get him to do something to help himself out of his immediate predicament. You can:

Steer him to community resources where he himself can apply for the help he needs.

Steer him to casual employment.

Talk to him about the repetitive pattern of his difficulties, the nature and proper treatment of his illness and how his problems can be permanently, not just temporarily, resolved this time by tackling his basic problem—alcoholism.

Encourage him to come back the next day to see you—sober.

Steer him to an alcoholism clinic, or if one is not available, to A.A. (for therapy, not for a handout.)

If in exceptional cases you do arrange for him to receive immediate material assistance, you should:

1. Be sure he has an appointment to see you the next day.
2. Arrange only short term, that is, day to day assistance. Avoid, if at all possible, giving money directly to him.
3. If he starts drinking, cut off assistance immediately and explain to him why you have done this.

Some Positive Responses

Finally, be prepared for a small percentage of positive responses to this approach. Perhaps not too many will come back, but even if they don't, you know that you have given of your time and of your concern. This is of more value to the individual eventually than giving him money. You will have helped him a little. However, if you give him a quick handout with no follow-up, you have in all probability only encouraged him to pursue his habitual patterns of behavior. What you really have done is just made yourself feel easier and more comfortable by providing quick, concrete, temporary aid of a kind.

If he responds positively to your initial approach, then in your follow-up interviews your approach to him may follow the general principles outlined to you earlier today when we discussed "Counselling the Alcoholic."

SOME parents want to train their children to have happy, full lives without the difficulties and dangers involved in the use of alcoholic beverages. Others wish to teach their children a moderate use of alcoholic beverages so that they may participate in social customs in which alcohol plays an important part. But all parents wish to avoid danger to the safety or health of their children that could result from a negative reaction to unreasonable restraint or from an indiscriminant endorsement of all use of alcohol without regard for the dangers involved. As different as the first two goals may be, the third is common to both, and certain prescriptions may be given to help accomplish it, regardless of which of the first two are sought.

A consistent family approach is needed for the child to respond to and adopt for his own the goals of his parents. The parents must reach some happy agreement. There should also be agreement between what is done and what is taught, including what the family endorses in the teaching of other agents—relatives, churches, schools, community. This approach should include satisfying ways for the child to meet his (not the parents') social situations.

Inconsistency is dangerous. Sometimes it is betrayal of announced family teaching by example or other non-verbal communication. Sometimes it comes as conflicting attitudes and values for which no solution is offered. Those teaching abstinence often give their children the impression through jokes, stories, etc. that they are really being deprived of something wonderful. Those who teach moderation often belie their overt confidence with the emotional content of their handling alcohol questions—guilt, impatience. The "naughty" interpretation of

This article is reprinted with permission from *The Alabama Challenge*. Its author was formerly Community Relations Associate for the Alabama Commission on Alcoholism and presently holds the position of Headmaster of the Self-Instructional School at Draper Correctional Center in Elmore, Alabama.

drinking activity by either shows ambivalence toward alcohol—on the "wet" hand that it is questionable, on the "dry" hand that it is fun.

A realistic interpretation of the facts of life in terms of the family's approach should be made. A child should be given a way of handling both the obvious abuses that occur on either side of the question, and the evident good seen from the opposite point of view.

It is neither safe nor fair to expect a child to develop his own rationale to deal with contradictory experiences or opposing views. Sometimes abstinence is supported with the statement that "good" (or healthy or wise, etc.) people do not drink and the recipient of this instruction then has to figure out how persons held in esteem by the family and community can drink. Sometimes indulgence is supported by statements that abstainers do not enjoy themselves and the child's experience contradicts this. Caricatures last only until reality appears, and then their effect is often reversed. Those who make, sell and drink alcohol rarely

for ALCOHOL EDUCATION in the FAMILY

By Al Vreeland

A consistent family approach to the use of alcoholic beverages is needed along with agreement between what is taught and what is done.

live up to the prohibitionist's description, and the moderationist's utopia simply does not exist.

Unadulterated facts about alcohol and its place in physiology, behavior, economics and society must be an ingredient of any alcohol education. These should be identified for the child as separate from the family's values and emotions. Only then can the child determine whether the firm facts support the family's approach. This judgment should be based on all the facts, not just those selected to support the family's view. Alcoholism can be avoided by factual understanding of its symptoms.

To edit, color or distort the truth in alcohol education shows a distrust of the family's position and of the child's integrity. It is dangerous, both for the blind spots it leaves in a child's understanding and for the negative reaction that may be expected when he acquires the omitted or more accurate information. To accommodate fact and fiction, to scare someone into conformity or to disguise a weakness in one's argument is to play havoc with the educational process. Misrepresentation of facts about alcoholism—whether to fight or protect drinking—is a real invitation to trouble.

Good mental health is the prime prescription for family alcohol education. Adequate self esteem is necessary to deal with the tensions inherent in social problems as well as to avoid a futile effort to escape oneself through alcoholism. Particularly in the presence of conflicting cultures and often the absence of a consistent satisfying culture, a feeling of personal worth and of the worth of other persons is demanded. Only an emotionally healthy person can internalize the family standards and act from within.

A sure way to sabotage the family's efforts to give useful guidance about alcohol is to deprive the child, through excessive protection or criticism, of the confidence he needs to meet personal and social problems. A child who seeks some way to escape unhealthy parental domination or make up for emotional deprivation is catapulted toward adolescent drinking excesses and possibly alco-

holism, regardless of punitive or negative family attitudes towards drinking.

Matter-of-factness should mark the parents' attitude. A calm and easy approach should be made to the facts about alcohol, to the problems presented by it, and to differing attitudes towards these problems. If this attitude is real for the parents, the children will adopt it, even though there are many things they cannot understand.

Overemphasis of alcohol (either way), tension about alcohol problems, embarrassment, hesitance or avoidance, excessive anger or anxiety only serve to increase the child's apprehensions and make him feel that he is in the presence of something dark and powerful, even magic. Some parents, thinking they are warning the child about danger or showing him proper use, actually may be teaching him, "If you want to be a person, (or independent, or sophisticated, or adult) this is what you use" or "I am afraid of this, but if you are smarter than I you can handle it" or "Regardless of your own preferences, you have to learn to drink like a lady or gentleman to be a person in our society." Undue attention puts a flashing sign before a child and gives him, particularly if he is unhappy, a ready way of acting out his feelings in often destructive ways. In the search for a cause of alcoholism in various cultures, anxiety about drinking seems to appear as the only constant factor.

Confidence in the family approach is contagious, even in nonverbal ways. It makes unnecessary any extreme statements or prohibitions and suggests to the child that a question or two will not destroy everything he has been taught, but strengthen it. It will also indicate to the child that if he challenges by his actions what he has been taught, his parents' guidance will be confirmed.

The parents' self-doubts will be communicated to the child even though an effort is made to confirm their teaching through the child's training and experience.

Definite rules and guidance should be given to the child to help him carry out the family attitudes in the use of alcohol, just as it is given in other areas of activity. These rules should be to help him, not place him in embarrassing or untenable predicaments with his peers. That they will be followed must depend on a positive attitude towards the family, not feelings of fear or guilt.

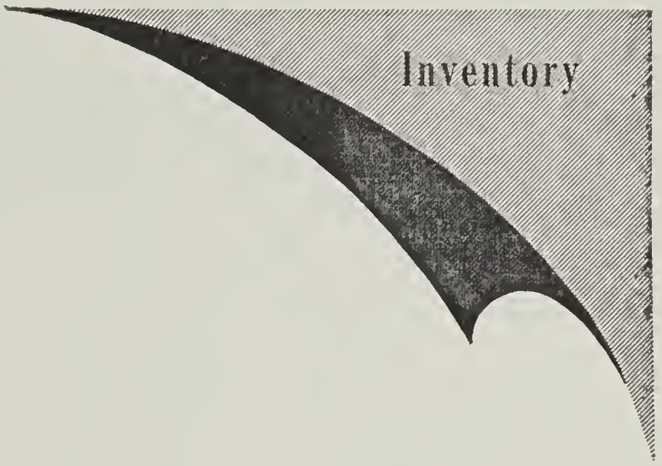
Failure to provide some explicit guide for conduct leaves a child open for embarrassment and through the parents' default a prey for coercion by irresponsible persons.

Security in the family circle is needed so that the son or daughter will not feel that carrying out the parents' wishes in this one matter is a test of family acceptance. This confidence in family support takes away the need to challenge authority in the peer group and is the best basis for adopting the family standard as one's own.

A young person whose place in the love and esteem of his family is jeopardized by some brief departure from family teaching is a poor risk for free intelligent action.

No one, of course, can tell others just what to teach their children or how to do it. The tried and acceptable forms of communication differ from family to family. These prescriptions may be summed up, however, in this way: have a consistent workable family way of using or not using alcoholic beverages and teach this to the children in the same manner that other family customs are taught.

EDITORIAL



YOUTH and ALCOHOL EDUCATION

THERE are many reasons for educating youth about alcohol—especially during the phase of growing up commonly known as adolescence—one of which is that there is a personal need for alcohol education on the part of the young people themselves.

Young people *will be* exposed to "education" about alcohol, though it may not be of the formal, meaningful variety which best serves the needs of youth. References to drinking occur in our songs, drama, advertising, religious ritual and leisure time activity. Over half of the adult population uses alcohol to some degree. Education which introduces young people to the accumulated scientific body of information about alcohol, then, may actually constitute a process of re-education.

Since alcohol is so prevalent symbolically in our society and since there are so many social models for drinking, almost every American will undergo some contact with it during the process of his socialization. Apparently, the adolescent who does not have to make a personal choice about drinking is relatively rare.

Alcohol education should aim to do more than present a knowledge of alcohol—what it is, how it acts, its benign and dangerous uses. It should seek to help the individual know himself, his society, and what society requires of him. The latter must necessarily incorporate the teaching of those characteristics an individual must develop to get along in American society. The individual who is aware of his own strengths and weaknesses, for example, will not have to resort to the use of alcohol as a problem-solving technique in meeting life situations.

Thorough application of this mental health approach in alcohol education with youth is at present the best known method of reducing the future rate of alcoholism with all its concomitant personal and social tragedy.

Though multiple factors are operative in all social problems, alcohol is involved as one causative factor in a number of social problems affecting millions of people in this country. Notable among them is the large number of traffic accidents in which

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THE ADOLESCENT IN AMERICAN SOCIETY

PART I

BY NORBERT L. KELLY, Ph.D.

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Much of the difficulty in understanding the adolescent comes from conflict over the fact that he is grown up and yet he really isn't grown up.

IN discussing the adolescent, I would like to emphasize that, basically, we will be dealing with problems of socialization.

Socialization refers to the processes by which an individual learns the culture of a specific society or social group in order that he may function adequately within it.

We must, therefore, turn our attention to the attitudes, the values, behavior patterns, standards of right and wrong, and expectations that contemporary America practices and presents to its youth as a model for emulation.

Youth, we must remember, does not create society.

Society precedes the child. It is in existence when he is born into it.

Let us look briefly at this American society into which the neophyte arrives and whose culture he must learn.

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The Adolescent in American Society was presented by the author at a conference on *Youth and Alcohol Education* held in the Summer of 1962 at St. Andrews Presbyterian College, Laurinburg, N. C. It, along with *Youth and Alcohol Use,* will be published in two parts, the second of which is scheduled to appear in the March-April, 1964 issue of *Inventory*.

YOUTH AND ALCOHOL USE

PART I

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Research is making it increasingly less necessary to speculate about what young people are thinking about, and what they are doing with, alcohol.

EVERY society stakes its life on the assumption that its youth are being prepared to become competent and responsible participants in community life. Since young people are both a living commentary on the generation that rears them and a prophecy about the generation that will inherit the future, many adults in our society continually view with interest and occasionally alarm, what young people are thinking and doing; the state of their health, education, and welfare; and any real or imagined indications of their incompetence or irresponsibility.

It is hardly surprising that we adults, who number our alcoholics and the cost of our misuses of beverage in the multiple millions, frequently look with some apprehension at what young people are saying about and doing with alcohol.

For years now parents, ministers,

Youth and Alcohol Use, which was also presented at the conference on *Youth and Alcohol Education,* is presented as a companion article to *The Adolescent in American Society.* Copies of the entire proceedings of the conference are available on request to interested persons, particularly those who are concerned with the education of youth about alcohol.

"Young people do not invent

educators, legislators, editorialists, and civic officials have exercised their right to speculate, with undetermined accuracy, about the drinking behavior and attitudes toward drinking among youth. There has not always been agreement among the speculators about whether contemporary young people should be indicted for a premature and too realistic imitation of adult drinking behavior or commended for not imitating this common facet of adult activity.

There is still room for argument about whether praise or blame is warranted. Fortunately, however, reseach is making it increasingly less necessary to speculate about what young people are thinking about and doing with alcohol.

In the past two decades there have been a number of research studies which describe and provide a factual basis for interpreting the drinking behavior and attitudes of adolescents, those persons who fall in the broad, loosely defined age range bounded on the one hand by puberty, and, on the other, by the assumption of adult roles. Over ten thousand young people living in various regions of the country have been involved in these investigations.

On the basis of cumulative research evidence here, in general, is what we know about drinking behavior and attitudes among contemporary adolescents:

1. The probability is quite high a young person will have experimented with at least one drink of alcohol before he is graduated from high school or reaches the age at which he would normally graduate.

2. First exposure of an individual to personal use of alcohol, in contrast to merely "tasting" an alcohol beverage, tends to occur about the time he is in junior high school or enters high school. A limited amount of "tasting" and ritual use of alcohol may occur before this time, but repeated personal use of alcohol before puberty is not common.

3. First exposures to personal use of alcohol are more likely to be in the context of the home with the parents or other relatives present than in other situations.

4. Beer is the most frequently consumed beverage; this choice seems to reflect both the availability and relative economy of this low alcohol content beverage.

5. If the parents in a family use beverage alcohol, the probability is that their adolescent children will also be or become users; and this probability increases with the age of the young person. Abstinent young people, on the other hand, typically have abstinent parents.

6. The proportion of *users* (those whose drinking involves more than a single isolated experience or ritual use of alcohol) among young people varies from community to community. In some communities majorities of six or eight in ten adolescents are *users*. In other communities only minorities of two or three in ten are *users*. Therefore, one cannot talk about the drinking behaviors or attitudes of teen-agers in general. This is also indicated by the next proposition.

7. Among young people, as among adults, the probability that an individual will be a *user* varies with such factors as sex, socio-economic status, religious preference and participation, ethnic background, and rural-urban residence. *Users* are more likely than others to be male, at the extremes of social status, iden-

tified with a religious or ethnic subculture which permits or encourages some use of beverage alcohol, and residing in an urban area.

8. Young people tend to perceive some use of alcohol as an integral part of adult role playing, particularly in situations in which adults are being convivial, celebrating a special event, or seeking symptomatic relief from tension and anxiety.

9. The probability that an adolescent will be a user of beverage alcohol increases with age; that is, as he approaches the achievement of adult status.

10. Young people tend to perceive alcohol as a social beverage rather than as a drug; they tend to emphasize in their descriptions of drinking what alcohol does *for* an individual at least as often as they emphasize what it may do *to* him.

11. Parental approval of some drinking experience for young people, especially if that drinking is in the context of the home, is frequently claimed by adolescent drinkers. The frequency of these claims varies from community to community and is presumably related to perceiver differences in the degree to which alcohol use is integrated into the normal social activities of adults.

12. Unqualified moral, religious, and legal injunctions against all use of alcohol as a beverage by minors are supported neither by the attitudes nor the behavior of young people. Only a minority of the adolescents who have been studied, even when they themselves are abstinent, consider alcohol use to be morally wrong for their peers under all circumstances, much less for adults. Although legal restraints may have effects, as yet undemonstrated, on where, when, and how alcohol is consumed, such restraints seem to have little effect on whether or not alcohol is used by adolescents.

13. The great majority of young people, even if they use beverage alcohol, do not appear to be preoccupied with drinking. Problems associated with use are not typical. The young person who drinks as often as an ounce a day; who is high, tight, or drunk with regularity; or who experiences repeated personal and social complications in association with drinking is not common. Estimates of the proportion of young people whose drinking is associated with personal or social problems vary from community to community and range from two to five percent.

14. While some peer group drinking among adolescents may reflect rejection of and hostility toward adult values and roles, such drinking behavior is not typical. On the contrary, most drinking by adolescents appears to be anticipatory of adult role playing and in conformity with perceived adult values. Tension is likely to develop not around the question of whether or not it is legitimate for an individual who has "come of age" to drink but, rather, the question of when an individual has, in fact, "come of age."

This, then, is the kind of information we have about what contemporary young people are thinking about and doing with alcohol. The essence of available research data seems most adequately expressed in a single conclusion: Young people do not invent the idea of drinking (or abstaining); they learn it.

The acceptability and desirability

of some drinking behavior is continually suggested to a young person by the elaborate integration of alcohol use into American culture and adult social behavior. A majority of adults in the United States drink at least sometimes; research indicates that the proportion of drinkers (about two out of three) and the drinking patterns of adults have remained relatively stable for the past two decades. Children, on the other hand, are generally assumed to be abstinent. Any attempt to explain the persistence of adult drinking behavior necessarily focuses attention on when and how the abstinence of childhood is transformed for the majority into the drinking behavior of adulthood.

An individual is born with the potentiality for becoming a social being. But whether and how this potentiality is developed and channeled are largely matters of learning. An individual's expectations, his attitudes, and his behavior are developed through contact with adult members of the species over a long period of time. His responses to persons and other objects and events in his external environment can be adequately understood only as one understands the traditional meanings which persons, objects and events come to have for him as a result of interacting with those persons who are significant in his experience. The individual never views the external world entirely free from the influence which these culturally defined and socially shared meanings and expectations come to have for him.

The system of traditionally defined meanings which serve as potential guides for behavior and which are shared with other members of a group is the phenomenon which we label *culture*. In becoming a social being, the individual may be said to be enculturated or socialized. He learns to play *roles* appropriate to a wide variety of social situations. When socialized individuals not only share role expectations about behavior but also sanction conformity to these shared expectations, behavior patterns are said to be *institutionalized*. From this point of view, most drinking behavior can be understood best as an aspect of culture, that is, as shared expectations about behavior. The use or non-use of alcohol is learned, institutionalized behavior for particular groups within the society and integrally related to a number of rules.

The availability of alcohol to members of a society does not in itself explain its use or non-use as a beverage. Whether one drinks and what, how, where, when, and with whom one drinks are institutionalized behavior for particular groups within the society. Although alcohol use is obviously a part of the cultural tradition of the United States, so also is abstinence. And, while some drinking is obviously institutionalized for some persons in some groups, whether one is encouraged, permitted, or forbidden to drink reflects such social factors as ethnic background, socio-economic position, religious orientation, age, and sex. Some uses of beverage alcohol are institutionalized among Orthodox Jews, for example; total abstinence is institutionalized among Mormons. Drinking is generally more permissible for the male than for the female and for the adult than for the adolescent. Therefore, in being socialized the individual is never exposed to culture in general; he is exposed to particular groups whose members introduce him to the institutionalized roles appropriate for him in that group. The male child, for example, does not learn only how to be a man; he must

also learn what it means to be a child as distinct from an adult, or perhaps, what it means to be white in contrast to Negro; middle class or lower class; Presbyterian or Baptist. He must learn whether or not drinking is ever appropriate; and, if it is, when, where, with whom, and to what extent it is appropriate. An individual's drinking behavior, if he drinks at all, typically conforms to the expectations of significant groups in his social environment.

Adolescence is of particular relevance in understanding the emergence of drinking or abstinent behavior in our society because it is obviously the transition between childhood roles and adult roles. The boundaries of introduction to this age-grade comes with puberty, i.e. about age twelve to fifteen; it is informally terminated by the assumption of adult-like responsibilities such as marriage, a full-time job, or entrance into the armed forces, normally upon graduation from high school at about age nineteen or formally by attaining the age of twenty-one. Adolescence, therefore, is roughly synonymous with the teen years and with participation in the junior and senior high school grades of our educational system. The precise determination of biological ages equivalent to the beginning and end of adolescence is neither possible nor relevant. What is important is the recognition that, in our society, adolescence is a transitional age-grade in which the individual is not any longer a child but yet not an adult. Literally the adolescent is in the process of becoming an adult; he is permitted and increasingly required with age to "play at" the institutionalized role behavior associated with adulthood. The adolescent, consequently, learns the attitudes toward the uses of beverage alcohol appropriate to adulthood as he has come to understand what it means to be an adult generally.

The perceived integration of some alcohol use into the style of life of many significant adults in the experience of most young people explains, at least in part, why one would expect and why one finds that among adolescents, the probability of alcohol use—as well as of smoking and heterosexual activity—increases with age, reaching its maximum degree about the time of graduation from high school. In our society graduation from high school is the point at which a majority of young people have assumed or will soon assume adult responsibilities associated with a full-time job, marriage, or entrance into the armed forces. One or more of these roles are likely to be assumed before the young person has reached the age of twenty-one, the age we usually associate with the end of adolescence.

THE ADOLESCENT

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Today, we are a highly urbanized society with more than two-thirds of our population living in towns and cities. We are an industrial and mechanical culture. We are a nation on the move, physical and social mobility increasingly characterizing our citizenry. Our world has become noted for its rapid social change.

For most of us, our way of life has changed rather drastically from that known to our grandparents. We now live in a society where inter-personal relationships are increasingly impersonal and fragmentary, where neighbors may not know each other, where expectations and the limits of acceptable behavior frequently are unclear.

Competitive pressures for all, including youth, apparently are greater than ever before. We, and our children, seemingly live in an age of American society when the real is not always the ideal. Many talk one value system and act another. No wonder youth seems to bewilder and confuse us at times. This is the very model we are presenting to them.

Apparently, we adults have no consensus concerning the role-behavior we expect of our youth. Thus, we not only present them with differing and conflicting models, but the various socializing agencies also suggest differing and conflicting expectations.

How integrated, we might ask, are the expectations presented to the adolescent by the family, on the one hand, and the school and church on the other?

In our society, the principal socializing agencies are the family, the peer group, the school, and perhaps, the mass media. The maturing child learns his group's culture largely in interaction with the significant "others" in his life. Some things he learns by direct teaching, or formal socialization, others he learns informally by observation of models. Regardless of what or how a cultural item is learned, in order for it to be incorporated into the personality it must be rewarding in some sense. Adolescents just don't do things. Things are done because they are gratifying or they lead to gratification. If they are not gratifying, they may be enacted to obviate guilt or shame. In any case, behavior is reward-oriented in some way. Frequently, the reward is a larger measure of self-approval gained by way of the approval of others for the action undertaken.

In recent years we have recognized in American society, especially in our middle socio-economic classes, a tendency toward delayed reward in some areas of behavior. Students of adolescence report that a "delayed gratification pattern" is held out to our youth and is being approximated. In return for future wealth, position, and influence, the middle class adolescent tends to avoid, for the present, sexual and other behaviors which would be immediately rewarding and pleasurable. Does this avoidance include the area of behavior that this conference is specifically interested in?

Understanding adolescence would be so much easier for us adults if we could accept the approach of the song writer who tells us that "In the wonder world of the young, youth is love." No doubt this activity is a necessary and involved part of youth behavior, but I don't believe it tells the whole story. The human being, even the young one, is somewhat more complicated and cannot be understood by a single motivation or type of behavior.

Conflict in Understanding

Much of the difficulty in understanding the adolescent comes from the fact he is grown up and yet he isn't grown up. This conflict may be seen in the very definitions of adolescence. Webster defines the term as follows: "Adolescence—the state or process of growing up from childhood to manhood or womanhood; youth, or the period of life between puberty and maturity."

The term *adolescent* is defined as "growing from childhood to maturity." It comes from the Latin *adolescere,* which means to grow up.

The word puberty, on the other hand, is defined as "The state or quality of being first capable of begetting or bearing offspring; the period at which sexual maturity is reached." Puberty comes from the

Latin word *pubertas*. It means *adult*.

In a sense, then, here's another basis for understanding some teen-age behavior: they are adults who are still in the process of "growing up."

Several centuries ago Shakespeare gave us a clue for further understanding human behavior. He reminded the Elizabethan world of man's stage-like journey through life. "All the world's a stage," he wrote, "and each man in his time plays many parts, his acting being seven ages."

Today, we accept a version of this developmental approach to human behavior and add to it. Not only does the human progress through life in a series of stages, or states, but he is also influenced at each stage by a number of variables from which he cannot escape.

The condition of his physical-being, for example, may be of great importance for the behavior he emits. For the adolescent this variable may be of prime importance.

The society in which the adolescent lives and develops may vitally influence his activity. The values, customs, and attitudes of a given culture or subculture become a part of the personality and help direct behavior.

The unique experiences each has plays a significant part in what each adolescent becomes, how he approaches life, what satisfactions or frustrations, fulfillments or anxieties he develops.

His *emotional needs* are still another significant aspect we must understand if we are going to comprehend his behavior. In a sense, these needs are of great significance for they operate as prime motivators and are intermixed with the experimental, the cultural, and the physical components of behavior.

The teener's emotional needs are related also to his *group affiliations* and the numerous roles he plays in this particular stage of development. To understand this complex young animal, we must view him in many guises: We must see him as a son, or daughter, as a sibling, friend, student, dater, worker, athlete, and in some cases as a delinquent. His roles might include also that of club or clique member, citizen, leader or follower, class officer, or church member.

Understandably, in the brief time I have, I cannot adequately cover all the factors pressing on the adolescent that have been mentioned. This would involve at least a semester's course. I shall, therefore, proceed selectively and hope that my selection does not produce distortion. The teener already suffers distortion too frequently.

One more preliminary point—when I use the word "adolescent", or "teen-ager" or "youth", I do so realizing that no two young people are exactly alike. No two have identical needs or experiences. Yet many have common traits and exhibit similar behaviors. To a real extent, then, when we use the terms mentioned we are talking in modalities or averages. *You* may know adolescents who manifest behaviors exactly opposite to those to be described as being held in common by many. Youth has its individuality as well as its conformity.

My admonition to remember that the teen-ager is an individual as well as a member of an age classification is apt, I believe, especially when you come across articles or books which sum up adolescents as the following two do: One writer describes adolescents as self-satisfied, unambitious, bland, secure, and cautious. Another depicts teen-agers as confused, dependent, afraid, seeking independ-

ence. Certainly all of these adjectives do not pertain to all youth. Yet, I'm sure that some of these traits are manifested by some teen-agers, perhaps many.

Who is the adolescent, anyway? A few seconds ago, I used the phrase "age classification." This introduces another area of confusion. Some authorities say adolescence begins around the age of eleven or twelve and runs through college. Obviously, you can't generalize about behavior over this wide age-span. Some have delimited discussion by dividing youth into *two sections* and talking about *early* and *late adolescence.* This helps somewhat. But there is still another obstacle to clarity. There are boys and there are girls. Their attitudes, values, and customs are not always the same. In this presentation, I suppose the only way I can bring any order out of this minor chaos is to indicate whom I'm talking about as I go along. In this way, perhaps we won't develop a feeling of storm and stress—the description that many once applied to adolescents in American society, but which nearly all authorities now tell us is not wholly true.

The necessity to see the adolescent as an individual which I emphasized previously, is essential in understanding his physical development during this period. While there are approximate averages in growth and development, each young person matures at his own pace. Some are early growers, some are late developers.

Girls tend to spurt ahead of boys in weight and height during early adolescence. On an average they arrive at puberty between the ages of twelve and fourteen. A few have their first menstrual period as early as nine or ten. Almost all are menstruating by sixteen.

Adolescents depend more on

For boys, the passage into adolescence is not marked so dramatically. The appearance of pubic hair is the signal that puberty has arrived. Most boys reach this stage between fourteen and fifteen.

For both boys and girls the rapid and uneven growth that occurs during adolescence may be the basis out of which psychological problems may develop. Shame and embarrassment may occur because *feet* seem large, *ears* outstanding, *Adam's apple* too prominent. A youngster may be painfully aware of a big nose. Being *too tall* or *too plump* is especially disturbing to girls. Some boys, conversely, find it hard to understand why they are not as big as their peers or as muscular. Feelings of inferiority may develop.

Some adolescents, of course, attempt to compensate by deviance for the inferiority and unhappiness they feel. Is this something we should consider as we talk about alcohol education with youth?

Understanding and accepting one's changing body and learning to care for it is one of the principal developmental tasks of adolescence. Other important tasks in this period of growth include achieving independence from the family and establishing a satisfying masculine or feminine identity.

The adolescent is growing toward maturity. There will come a time when he will have to leave childhood behind and enter the world of adult responsiblity. But this is a process that does not happen overnight. One learns adulthood.

For many young people, learning to be adult is not easy. Striving for independence in one's behavior,

parental regulations than is commonly assumed.

seeking to escape parental controls, wanting to grow up, in other words, may elicit adolescent actions that are easily misunderstood by one's family. Parental control efforts may be reasserted and, unwittingly, the drive toward independence and self-sufficiency may be hampered or even thwarted. This is especially true of early adolescence, the years roughly from twelve to fourteen.

The early adolescent may be a fairly constant irritant to his parents. Seemingly, he vacillates between being greatly resistive and very compliant. He frequently is a creature of extremes. He may be erratic. He is also fighting hard to emancipate himself. The more his parents resist his efforts toward independence, the harder he fights for it. During early adolescence, insolence, impudence, carelessness, silliness, disrespect, and boisterousness are behaviors to be expected. Extreme dress, emotional outbursts, poor table manners, nail-biting, and tics are also common manifestations of the search for adulthood and emancipation from parental control. His room is usually a jungle of disorder. Sprawling on its floor, amidst a vast disarray of clothes, books, games, shoes, comics, and sundry other tangled articles, the early adolescent seems to be issuing his own private declaration of independence.

For the average parent, much of this behavior is hard to understand and a lot of it is frustrating. *Conflict* between parents and child may easily develop. Insight, patience, and humor definitely seem to be in order for the parents of an early adolescent.

The older adolescent has begun to achieve more independence. While conflict areas may still exist, especially over money matters, dating, and the family car, youth in the fifteen year and older category tend to be more accepting of their parents. They have grown to the point where they have started thinking about other peoples' needs and feelings. They are less egocentric.

Some rather limited studies of adolescence give the impression that American youth live in a social world all of their own, rather completely cut off from adult culture and relatively isolated from their families. Such studies overemphasize, perhaps, the teen-agers' involvement in *peer groups* and the supreme importance of these groups in directing and motivating adolescent behavior. *Unquestionably, the peer group is highly significant.* But independent research on both adolescent boys and girls reveals that the family is still a very important influence in their lives.

In one nation-wide study of a large sample of 14 to 16 year old boys, the authors concluded, "We have seen that boys are far from independent of family ties. In fact, to a very large extent their strivings and aspirations, concerns and satisfactions are parent-centered. They are more attentive to parental attitudes and more dependent on parental regulations than is commonly assumed." In the same vein, they write: ". . . few boys value the opinions of peers compared to parents."

In another national study, nearly three-quarters of the adolescents sampled specified that they would turn to their parents first when they need advice. To keep the record straight, however, less than half of

the sample discussed *all* serious problems with their parents.

A third study, this time of adolescent girls between the ages of 11 and 18, revealed that the person chosen most often as the ideal woman from whom to learn appropriate behavior was *mother*. The second most popular female model was the school teacher.

This same research showed that 91 per cent of the girls sampled *share leisure-time activities with their families* and only five per cent believed that all girls could get along on their own without parental authority. This latter point would seem to indicate a healthy respect for the security and guidance of the family.

On the other hand, we must point out that many young people report that their parents are not infrequently a source of embarrassment to them. Adolescents dislike it very much when their parents talk about them in front of other adults. They complain of parents being overly effusive with their friends. They are very critical of parents who don't act their age.

In the study of adolescent girls mentioned previously, it was found that *many parents* have clear-cut *expectations* of their teen-agers. They expect them to show proper manners in terms of politeness, neatness, and lady-like language. They want them to be skilled in interpersonal relationships, to know how to get along with people. And they expect them to respect the authority of parents and elders. The importance of adhering to conventional morality is stressed. But only about *one per cent* of the entire sample reported that their parents emphasized that they *should not drink alcoholic beverages*. No doubt this is a point we should keep in mind in our discussions on alcohol education.

ALCOHOL EDUCATION

CONTINUED FROM PAGE 15

alcohol is implicated with their resulting financial costs, bodily injuries, and deaths. From 40 to 50 percent (some estimates are higher) of jail and prison occupants are afflicted with personal maladjustment in which alcohol is one important etiological element. Add to this the rapid social change—which today's adults can visualize by comparing their way of life with that of their parents or grandparents—to which youth is subjected in our highly industrialized and motorized society, and it becomes increasingly evident that a knowledge of alcohol on the part of youth may be a matter of survival to many. Youth must learn, for instance, that alcohol cannot be mixed with modern complex industry, with its modern complex machinery, or with the driving of motor vehicles. And neither can it safely be used as a method of adjusting to social change or solving personal problems.

Alcohol education which serves the needs of youth must be based on a knowledge and understanding of youth in American society. In order to communicate effectively with youth, a knowledge (not speculation) of what young people are thinking and doing about alcohol becomes essential. Fortunately, more and more study is being given to both areas with the result that more and more information is available to teachers, parents, churches and others who are concerned with education of youth in this area. The articles by Drs. Kelly and Maddox in this issue, to be continued in the March-April issue, are highly recommended as the kind of background information on which to base effective alcohol education with youth. (L. P.)

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riety; homicide, assault, rape and the like. Such a defendant may have already shown a tendency to mix alcohol and violence. If it can be established that that individual is also an alcoholic, is he nevertheless a menace to society? Should he be released? Should he be committed to a mental hospital, or directed to a clinic—the medical profession — for rehabilitation? Is the medical profession prepared, with their present knowledge, to give assurances that cases of this kind can be successfully treated? Perhaps a valuable law in this difficult area would be treatment-early-release provisions which would make prison rehabilitation programs, for example, more effective. Are such programs available?

The past decade has produced volumes of articles, reports and books relating to driving motor vehicles while under the influence of alcohol. Each publication usually commences with rather astonishing statistics relating to highway fatalities, then procedes to discuss chemical testing, various constitutional questions raised in consent legislation and the use of chemical testing, and ends with the admonishment that alcohol and driving do not mix. The statistics seem to suggest that as a matter of fact alcohol and driving do definitely mix in our society. The causal relation between the ingestion of alcohol and accidents may be questioned, although such relationship does exist in some cases. It seems reasonable to assume, however, that as long as alcohol and motor vehicles exist in society, drinking and driving in combination will exist. The law recognizes this to an extent by requiring the driver to be under the influence to at least a minimum degree as held in evidence before he is charged. If the law did not recognize this, we would predict a breakdown in enforcement.

Our drinking society is to be found in taverns, at their neighbors, night clubs, cocktail parties, etc.—drinking in a social setting. Drinking alone at home may be viewed by some with suspicion. The value of a law which is widely disregarded has been demonstrated by prohibition. Would it be in the interest of an effective social policy to find, therefore, a reasonable balance between the drinking and driving society and the threat of highway accidents? Would education that drinking and driving requires a much higher degree of caution be more advantageous than emphasis on complete abstinence? The relentless repetition of accidents and highway fatalities urges a more realistic, effective partnership between the law and the corrective forces in our society, particularly with regard to the drinking-driving public.

The area of greatest neglect, yet of greatest numbers, is the cases involving misdemeanors most commonly charged as "public intoxication." It has been estimated that these cases total more than a million and a half annually. The vast majority involve the chronic police case inebriate—the repeater. Such persons have been identified elsewhere in the majority as the homeless or skid-row alcoholics. Only a small percentage of alcoholics can be classified as skid-row. Similarly, only a small percentage of inhabitants of skid row can be classified as alcoholic. Yet the skid-row problem drinkers represent probably the major law enforcement problem in our society today. From available evidence it is obvious that the punitive approach to the chronic police case inebriate has been a com-

(Continued on page 30)

A feature designed to help you keep posted on developments in the field of alcoholism.

RALEIGH, N. C.: The NCARP joined with other state and local alcoholism programs throughout the nation in observing Alcoholism Information Week December 1-7. The mass media were used effectively in focusing attention on alcoholism during this special week. All radio and television stations in North Carolina were sent spot announcements and newspapers throughout the state received news releases, pictures and mats for use during Alcoholism Information Week.

CHARLOTTE, N. C.: Reverend Joseph L. Kellermann, director of the Charlotte Council on Alcoholism, has been invited to speak on alcoholism at the 15th annual meeting of the National Catholic Clergy Conference in New Orleans on April 1.

RALEIGH, N. C.: On January 29, just in time to make **Inventory's** deadline, the stork delivered a baby daughter to editor Lillian Pike and her husband. Mother and daughter are doing nicely and we welcome little Beverly Inez into our NCARP family—perhaps, even, as a future editor of **Inventory!**

BROMIDE DANGERS: A three-year study by two North Carolina psychiatrists gives evidence that overdoses of medicines containing bromides, which are used to calm excess emotional disturbances, can cause behavior so similar to mental illness that only blood tests can really pinpoint the difference. Results of the study were included in a report made by Dr. John A. Ewing, professor of psychiatry at the University of North Carolina School of Medicine; and Dr. W. J. Grant, staff member at the Child Guidance Clinic in Winston-Salem, to the Southern Medical Association at its annual meeting in New Orleans.

Doctors Grant and Ewing said their study of more than 1,200 mental patients in North Carolina hospitals showed that as many as one of every ten had taken some bromides. One of every 200 had taken excessive amounts, the doctors said. The effect of the bromides on the patients varied from drowsiness to sleeplessness and from quiet depression to wild behavior bordering on insanity, the report stated.

The bromide medicines can be purchased at drugstores without a physician's prescription although they are potentially hazardous. Doctors Ewing and Grant have urged physicians to help educate the public to what they call the hazards of self-medication with bromide medicines, and have suggested that blood bromide tests be given routinely to mental patients on admission to hospitals.

RALEIGH, N. C.: Plans are already underway for summer courses of study on alcoholism and on mental health to be sponsored by the NCARP in conjunction with several North Carolina colleges this summer. Summer studies on facts about alcohol will be held at the University of North Carolina, East Carolina College and Winston-Salem Teachers College, and an institute on mental health is scheduled to be held at St. Andrews Presbyterian College.

BURLINGTON, N. C.: North Carolina has recently added a new local alcoholism program to its growing list of communities having such programs. The Alamance County Council on Alcoholism, headed by Mrs. Margaret Brothers who was formerly wth the Greensboro Council on Alcoholism, opened its doors recently. Offices are located at room 802 in the N. C. National Bank Building. This brings to sixteen the number of local alcoholism programs in North Carolina.

CHAPEL HILL, N. C.: The National Institute of Mental Health has approved a new two-year grant of $34,000 to the University of North Carolina to continue a study of experimental alcoholism. Dr. Fred W. Ellis, associate professor of pharmacology at the UNC School of Medicine, is in charge of the research project. The work, which has been conducted under another federal grant for the past five years, involves an attempt to find out what effect the long-time use of alcohol has on various body chemicals in animals.

FINLAND: A law on compulsory treatment for persons between 18 and 25 years of age who are "given to insobriety" or who repeatedly use alcoholic beverages "improperly" has been adopted in Finland. Treatment may include "advice and guidance, surveillance, or treatment at an institution or other center." Under the law, persons may be committed to treatment centers for a year or more but may be released earlier by the facility. The law also provides for voluntary admissions to treatment facilities for set periods of time.

RALEIGH, N. C.: A decline in the state's prison population has brought it to an all-time low, state prisons director George W. Randall has reported. The present population of 10,512 is far below the 13,900 expected to be in prison at this time. Mr. Randall credits the prison system's rehabilitation program for the encouraging trend, and goes on to say that one of the greatest rehabilitating devices is work. By teaching the prisoner a skill he can perform outside of prison, he is helped to find his place in society before he is even returned to it. Mr. Randall also cites Alcoholics Anonymous as a valuable rehabilitative force for inmates. An outstanding AA program is an integral part of the prison system and records show that more than 2,000 prisoners who have joined AA have never returned to prison.

WASHINGTON, N. C.: The committee on alcoholism of the Beaufort County Mental Health Association, in cooperation with the Beaufort County A. B. C. Board, the N. C. Mental Health Association, and the N. C. Department of Mental Health, has planned a month-long program of alcohol education for the public and for various professional groups. The program will open in Washington on February 2 with a special program for the public and close on February 28 with a session for social workers, public health nurses and institutional nurses. Other programs have been planned especially for physicians, ministers, law enforcement officers, court officials, and teachers. Dr. Norman Desrosiers, medical director of the North Carolina Alcoholic Rehabilitation Center at Butner, will be the guest speaker at the sessions for law enforcement officers, court officials and ministers; and NCARP associate director Norbert L. Kelly and Psychiatric Social Work Consultant Roberta Lytle will lead the sessions programmed for teachers.

plete, dismal failure. There is evidence that such an approach tends to decrease the possibility of successful rehabilitation because of the negative influences of incarceration. In addition to being an inhumane, ineffective solution, the punitive approach costs society large sums in terms of men and facilities required to continue the "revolving door."

One suggested solution is to ignore the problem, repeal the public drunkenness statute and require something more than mere public intoxication for arrest. New York City recently repealed its public drunkenness ordinance thus making the law conform with their courts' actual practice of requiring a "disorderly conduct" charge. This practice may possibly be deemed an affirmative response to a serious constitutional question regarding the right of a person to be drunk and deviant, so long as this behavior does not come in conflict with other people. This suggested New York solution may well be workable as a stop gap measure and relatively inexpensive, provided the skid-row section is isolated and properly patrolled and municipal shelters are maintained to which intoxicants may be transferred from the street.

Another suggested approach is to require some type of compulsory treatment. Although many therapists have reported favorably on their treatment results under such conditions, there seems to be fairly general agreement that compulsory treatment is unsatisfactory. Certain voluntary programs, such as halfway houses, aided by Alcoholics Anonymous members, have demonstrated an encouraging degree of success.

Is the law not entitled to a new alternate approach in this area of alcohol problems, an approach which combines clinical systematic treatment, physical, mental, and social rehabilitation, using the half-way house as a transition between the treatment center and society? Almost all current programs neglect one or all of the essentials of the above steps. Perhaps a logical point of beginning would involve consideration of such questions as to whether there is a need for revisions in the law, for a more realistic, sympathetic understanding in the application of our present laws; and/or for cooperative planning by the police, courts and correctional services in developing procedures which will emphasize rehabilitation opportunities rather than punitive measures.

Domestic Relations

The domestic relations judge often comes into contact with alcohol problems in connection with cases involving divorce, non-support, neglect of juveniles and the like. The abnormal drinkers involved in such cases are often of a different type than those other judges encounter. While the drinking pattern may appear to be symptomatic of alcoholism, such a diagnosis may be premature or may never become valid. Usually the offending party has not severed relations with his family; he may continue to be employed and to otherwise maintain his normal social relationships. The fundamental importance of the family in our society places a great responsibility upon this division of our court system. It seems reasonable to assume that society may or does expect of this court remedial decisions beyond the more specific legal remedies. Since drinking problems are often involved in these cases, is not society also guilty of neglect if it does not provide such courts with adequate diagnostic and therapeutic resources?

There are a number of statutes dealing with alcoholism which do not have relation to other areas of the law. Compulsory hospitalization of alcoholics as mentally ill persons is one such law. One question to be raised is where are these people to be confined? If in a state mental hospital, is the hospital and staff adequately equipped to effectively treat such problems? Again, a question may be raised as to the constitutionality of such procedures. Does a citizen have a right, if he wishes, to remain an alcoholic? Since his illness is usually directly affecting others, his wife or children, this issue probably can be overcome, provided the legislation has sufficient safeguards in other respects.

In the past decade state and municipal law has entered into the area of legislation designed to provide or relating to the prevention and control of alcoholism and the rehabilitation of alcoholics. Such legislation has generally included the establishment of alcoholism programs at the state and/or local levels. These programs are founded upon the premise that alcoholism is a disease which can and should be treated as such. In 1960, forty-four such programs existed. The pattern established by the Ohio Department of Health emphasizes local programs consisting of: (1) a community facility to provide for dispensing alcoholism information, counseling and referral assistance; (2) education of the general public and professional orientation regarding alcoholism; (3) the mobilization and coordination of community resources required for an effective rehabilitation program, and the cooperative development of new services which cannot be accommodated within existing treatment facilities; (4) advancement of research—developing studies regarding the extent and nature of the community problem, stimulation and promotion of depth research by competent personnel, and making research findings available to professional groups. Since many statutes spell out that alcoholism is an illness, an interesting legal by-product of these laws may be their effect upon other areas of the law discussed in the foregoing pages.

A popular cliche is that the law lags behind the times, and this certainly carries some truth. In the area of alcoholism, we would suggest the times is the true laggard. An aura of mystery has surrounded alcoholism since the birth of civilization, and it seems, to a large extent, society continues to prefer to deny it, hide it or accept it philosophically, without apparent interest in remedial action. The law is probably not lagging any further behind than medicine and the other sciences. Apparent inadequate solutions and confusion to be associated with interpretations of the law result as much from lack of alternatives as from any other reason. Nevertheless, the author has endeavored to cite a number of issues which should be of particular concern to the draftsmen and interpreters of our laws.

Furthermore, an obligation exists with the legal profession, as other professions, to learn and understand alcoholism and to discover what are the best legal resources available to deal with the illness. As in other areas where public funds are concerned, the legal profession has an obligation to be one of the standard bearers in the development of facilities and personnel dedicated to the prevention and control of this major public health problem, which in Ohio involves an estimated 250,000 alcoholics and probably close to another 750,000 dependents and family members directly affected.

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ASHEVILLE—

**Educational Division, Board of Alcohol Control;* Parkway Office Building; Phone ALpine 3-7567.

†*Mental Health Center of Western North Carolina, Inc.;* 415 City Hall; Phone: ALpine 4-2311.

BURLINGTON—

**Alamance County Council on Alcoholism;* Margaret Brothers, Executive Director; Room 802, N. C. National Bank Building; Phone: 228-7053.

‡*Outpatient Clinic;* Alamance County Hospital; Hours: Wed., 9:00 a.m.-4:00 p.m.

BUTNER—

‡*Aftercare Clinic;* John Umstead Hospital; Hours: Mon. Fri., 9:00 a.m.-4:00 p.m.

CHAPEL HILL—

†*Alcoholism Clinic of the Psychiatric Outpatient Service;* N. C. Memorial Hospital; Phone: 942-4131, Ext. 336.

**Orange County Council on Alcoholism;* Dr. D. D. Carroll, Director; 102 Laurel Hill Rd.

CHARLOTTE—

**Charlotte Council on Alcoholism;* Rev. Joseph Kellermann, Director; 1125 E. Morehead St.; Phone: FRanklin 5-5521.

‡*Mecklenburg Aftercare Clinic;* 1200 Blythe Blvd.; Hours: Mon.-Fri., 8:00 a.m.-5:00 p.m.

†*Mental Health Center of Charlotte and Mecklenburg County, Inc.;* 1200 Blythe Blvd.; Phone: FRanklin 5-8861.

CONCORD—

†*Cabarrus County Health Department;* Phone: STate 2-4121.

DURHAM—

‡*Aftercare Clinic;* Watts Hospital; Hours: Tues. and Fri., 2:00-5:00 p.m.

**Durham Council on Alcoholism;* Mrs. Olga Davis, Executive Director; 602 Snow Bldg.; Phone: 682-5227.

FAYETTEVILLE—

†*Cumberland County Guidance Center;* Cape Fear Valley Hospital; Phone: HUdson 4-8123.

GASTONIA—

†*Gaston County Health Department;* Phone: UNiversity 4-4331.

GOLDSBORO—

‡*Outpatient Clinic;* Cherry Hospital; Hours: Tues. and Fri., 10:00 a.m.-12:00 noon. Thurs., 2:00-4:00 p.m.

**Wayne Council on Alcoholism;* A. T. Griffin, Jr., Executive Director; P. O. Box 1320; Phone: 734-0541.

GREENSBORO—

**Greensboro Council on Alcoholism;* Worth Williams, Executive Director; 216 W. Market St., Room 206 Irvin Arcade; Phone 275-6471.

†*Guilford County Mental Health Center;* 300 E. Northwood St.; Phone: BRoadway 3-9426.

†*Family Service Agency;* 1301 N. Elm St.

‡*Outpatient Clinic;* 300 E. Northwood St.; Hours: Mon. and Thurs., 5:00-10:00 p.m.

GREENVILLE—

†*Pitt County Mental Health Clinic;* Pitt County Health Department, P. O. Box 584; Phone: PLaza 2-7151.

HENDERSON—

**Vance County Program on Alcoholism;* Dr. J. N. Needham, Director; 2035 Raleigh Rd.; Phone: GEneva 8-4702.

HIGH POINT—

†*Guilford County Mental Health Center;* 936 Mountlieu Ave.; Phone 888-9929.

JAMESTOWN—

**Alcohol Education Center;* Ben Garner, Director; P. O. Box 348; Phone: 883-2794.

LAURINBURG—

**Scotland County Citizens Committee on Alcoholism;* M. L. Walters, Executive Secretary; 308 State Bank Bldg.; Phone: 276-2209.

MORGANTON—

‡*Aftercare Clinic;* Broughton Hospital; Hours: Mon.-Fri., 2:00-4:00 p.m.

NEW BERN—

**Craven County Council on Alcoholism;* Gray Wheeler, Executive Secretary; 411 Craven St., P. O. Box 1466; Phone: 637-5719.

*†*Psychiatric Social Service,* Craven County Hospital; Phone: 638-5173, Ext. 294; Hours: Mon.-Fri., 9:00 am.-5:00 p.m.

NEWTON—

**Educational Division, Catawba County ABC Board;* Rev. R. P. Sieving, Director; 130 Pinehurst Lane; Phone: INgersoll 4-3400.

RALEIGH—

‡*Aftercare Clinic;* Dorothea Dix Hospital, S. Boylan Ave.; Phone: TEmple 2-7581; Hours: Mon.-Fri., 1:00-4:00 p.m.

†*Outpatient Clinic of the Mental Health Center of Raleigh and Wake County, Inc.;* Wake Memorial Hospital; Phone 834-6484; Hours: Mon.-Fri.; 8:30 a.m.-5:30 p.m.

SALISBURY—

**Educational Division, Rowan County ABC Board;* Peter Cooper, Director; P. O. Box 114; Phone: 633-1641.

†*Rowan County Mental Health Clinic;* Community Bldg., Main and Council Sts.; Phone: MElrose 3-3616.

SANFORD—

†*Mental Health Clinic of Sanford and Lee County, Inc.;* 106 W. Main St. P. O. Box 2428; Phone: 775-4129 or 755-4130.

SHELBY—

†*Cleveland County Mental Health Clinic;* 101 Brookhill Rd.; Phone: 482-3801.

SOUTHERN PINES—

**Moore County Alcoholic Education Committee;* Rev. Martin Caldwell, Director; P. O. Box 1098; Phone: OXford 2-3171.

†*Moore County Mental Health Clinic, Inc.;* Box 1098; Phone 695-7781.

WILMINGTON—

†*Mental Health Center of Wilmington and New Hanover County;* 1013 Rankin St.; Phone: ROger 2-8294.

**New Hanover County Council on Alcoholism;* Mrs. Margaret Davis, Executive Secretary; 211 N. Second St.; Phone: 736-7732.

WILSON—

‡*Aftercare Clinic;* Encas Station; Hours: Mon.-Fri., 8:00 a.m.-5:00 p.m.

†*Wilson County Mental Health Clinic;* Encas Rural Station; Phone: 237-2239.

WINSTON-SALEM—

*†*Alcoholism Program of Forsyth County;* Marshall C. Abee, Executive Director; 802 O'Hanlon Bldg., 105 W. 4th St.; Phone: PArk 5-5359.

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